2018-19 Employer Data Worksheet for TLC Health Benefits Program

This is a Worksheet only.

Contact Ann Wohl at DHRM with any questions about this form.

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Group Information:

1. Enter the group name.

Group Name:

2. Check one:

○ Stand-alone Government Group	○ Stand-alone School Group	○ Combined Government & School Group

3. Check one and enter dates.

○ Existing Group–July Renewal	Plan Year Begins: 07 / 01 / 2018	Plan Year Ends: 06 / 30 / 2019
○ Existing Group–October Renewal	Plan Year Begins: 10 / 01 / 2018	Plan Year Ends: 09 / 30 / 2019
○ Existing Group–Mid-Year Plan Change	Change Begins: ____ / 01 / ____	Plan Year Ends: ____ / 30 / ____
○ New Group	Plan Year Begins: ____ / 01 / 2018	Plan Year Ends: ____ / 30 / 2019

Federal Employer Identification Number(s) and DHRM Group Number(s):

4. A group must have a subdivision for each Federal Employer Identification Number (FEIN). Subdivisions with the same FEIN are also permitted.

Check one: ○ This group has only one subdivision.
○ This group has more than one subdivision.

Enter the information for each subdivision. List the primary subdivision (leader) first.

Subdivision Name List the primary subdivision (leader) first.	Subdivision FEIN	Subdivision Type	DHRM Group Number Agy:	 Grp:	 Sub:
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			
		☐ Government ☐ School			

Group Name: _____

Open Enrollment, Election Changes, Classifications and Counts:

5. Check one: ○ This group has only one subdivision – apply selections on this Page 2 to it.
   ○ This group has more than one subdivision – each subdivision must submit a Page 2.
   Apply the selections on this Page 2 to the following subdivision:
   Subdivision Name:_____

6. An Open Enrollment period no longer than 30 days between April 1 and May 15 for groups renewing in July, and between Jul 28 and September 10 for groups renewing in October is required. New groups must have an Open Enrollment period approved by TLC prior to the effective date. Enter Open Enrollment (OE) Dates: Begins:____/____/____ and Ends:____/____/____

7. TLC requires that all groups are subject to theTLC enrollment and election change time limits for initial enrollment, mid-year election changes and terminations as described on the TLC Enrollment Form and in the Member Handbooks. The only exceptions are groups that have their own plan document defining more restrictive qualifying mid-year event rules or groups with enrollment rules that take into consideration a waiting period which cannot be more than 90 days.

   TLC requires that an Initial Enrollment request be received within 30 days of beginning employment or from the end of the waiting period if applicable. Does this group **have a plan document that allows an enrollment period greater than 30 days (and not more than 60 days) from the date of hire or end of waiting period?** ☐ Yes ☐ No

   TLC requires that a Qualifying Mid-Year Event (QME) change request be received within 60 days of the event. Does this group **have a plan document that requires a window more restrictive than 60 days to report a QME?** ☐ Yes ☐ No

8. Check "yes" or "no" for each classification offered coverage, check the billing method and enter the current counts.

Classification	Offer Coverage?	Billing Method	Enter Enrolled Count	Enter Waived Count	Enter Eligible Count (Enrolled + Waived)
Full-time Employees	☐Yes	☐Bill the Group			
Part-time Employees	○Yes ○No	☐Bill the Group			
Elected Officials with full-time premium	○Yes ○No	☐Bill the Group			
Elected Officials with part-time premium	○Yes ○No	☐Bill the Group			
Extended Coverage/COBRA Qualified Beneficiaries .	☐Yes	○Bill the Group ○Direct Bill ○Third-Party Administrator*		NA	NA
Early Retirees – not eligible for Medicare	○Yes ○No	○Bill the Group ○Direct Bill ○Third-Party Administrator*		NA	NA
Medicare Retirees – eligible for Medicare	○Yes ○No	○Bill the Group ○Direct Bill ○Third-Party Administrator*	NA	NA	NA
Split Contract Dependents of Retiree	○Yes ○No	NA – former billing method is continued	NA	NA	NA
Survivors of Employees & Elected Officials Former coverage and premium is continued for one extra month	○Yes ○No	NA – former billing method is continued		NA	NA
Survivors of Retirees	○Yes ○No	NA – former billing method is continued		NA	NA
Long-Term Disability Participants	☐No	NA	NA	NA	NA
		Enter Participation Counts: (Excluding the shaded counts, sum each column.)			

* When a Third-Party Administrator (TPA) is used, Direct Bill is not permitted.

Participation, Plans and Premiums:

9. Check one: ☐ This group has only one subdivision – apply the selections on this Page 3 to it.
   ☐ This group has more than one subdivision – apply the selections on this Page 3 to all subdivisions.
   ☐ This group has more than one subdivision - apply the selections on this Page 3 to the following subdivision:
   Subdivision Name:_____

10. Calculate the Total Group Participation Percentage.

Sum the Enrolled Count for all subdivisions and enter the Total Group Enrolled Count:	
Sum the Eligible Count for all subdivisions and enter the Total Group Eligible Count:	
Divide the Total Group Enrolled Count by the Total Group Eligible Count and enter the Total Participation Percentage: (Round percentage down)	%

11. Check one: ☐ Premium Averaging is not used.
   ☐ Premium Averaging is used.

12. Check one selection for each plan choice and enter the contribution amounts for each plan selected.

	Self Only		Self + One		Self + Family	
Key Advantage Plan Choice 1:	☐ KA Expanded ☐ KA 250		☐ KA 500 ☐ KA 1000 ☐ None			
Comprehensive Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
Preventive Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
Key Advantage Plan Choice 2:	☐ KA Expanded ☐ KA 250		☐ KA 500 ☐ KA 1000 ☐ None			
Comprehensive Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
Preventive Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
High Deductible Plan Choice:	☐ with employer HSA/HRA funding ☐ without employer HSA/HRA funding ☐ None					
Comprehensive Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
Preventive Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
Regional HMO Choice:	☐ Kaiser HMO ☐ None					
Total Premiums	$		$		$	
	Employer	Enrollee	Employer	Enrollee	Employer	Enrollee
Full-time	$	$	$	$	$	$
Part-time	$	$	$	$	$	$
Medicare Plan Choice:	☐ Advantage 65 ☐ Advantage 65 + Dental/Vision ☐ Option 1 ☐ None					
Total Premiums	$					

Group Name: _____

Contact Information:

13. Check one: ○ This group has only one subdivision – apply the selections on this Page 4 to it.
○ This group has more than one subdivision – apply the selections on this Page 4 to all subdivisions.
○ This group has more than one subdivision - apply the selections on this Page 4 to the following subdivision:
Subdivision Name:_____

14. Enter the Mailing Address:

Street or P O Box:			Suite:
City:		State:	Zip+4:

15. Enter the Shipping Address (physical location). ☐ Shipping Address same as Mailing Address.

Street or P O Box:			Suite:
City:		State:	Zip+4:

16. Enter the Benefits Administrator's information. This person handles eligibility and enrollment.

First Name:	Middle Initial:	Last Name:		Suffix:
ID or SSN:		Date of Birth:		
Email:				
Phone: ( ) -		Ext:	Fax: ( ) -	

17. Enter the Benefits Executive's information. This person authorizes the renewal.

First Name:	Middle Initial:	Last Name:		Suffix:
ID or SSN:		Date of Birth:		
Email:				
Phone: ( ) -		Ext:	Fax: ( ) -	

18. Enter the Billing Administrator's information. This person receives and handles inquiries about billing.

First Name:	Middle Initial:	Last Name:		Suffix:
ID or SSN:		Date of Birth:		
Email:				
Phone: ( ) -		Ext:	Fax: ( ) -	

19. Enter the Billing Executive's information. This person authorizes premium payments.

First Name:	Middle Initial:	Last Name:		Suffix:
ID or SSN:		Date of Birth:		
Email:				
Phone: ( ) -		Ext:	Fax: ( ) -	

20. Enter the Employer Certification. For groups with more than one subdivision, this is the primary subdivision (leader).

I certify that the information on this form is complete and accurate to the best of my knowledge. ○ Yes ○ No			
Signature:			Date Signed:
Printed Name:		Phone: ( ) -	Ext: